

CAP Accommodation Request Form

CAP Office Use Only	
Received:	_____
<input type="checkbox"/> EFMP	<input type="checkbox"/> Tele
Completed:	_____
<input type="checkbox"/> DDESS	<input type="checkbox"/> WC
Approved:	_____
<input type="checkbox"/> DoDDS	<input type="checkbox"/> CTRS
Ordered:	_____
<input type="checkbox"/> MHS	<input type="checkbox"/> DoD
Declined:	_____
<input type="checkbox"/> Non-DoD	<input type="checkbox"/> State
Canceled:	_____
Request #:	_____
Vendor:	_____
Order #:	_____
Item Description:	_____

CAP ACCOMMODATION REQUEST FORM

Complete this form to request assistive technology and services. All information will be kept confidential. Please ensure completion of all contact information. Approval is required from requester's supervisor. Signature certifies that the accommodation is necessary for a person with a disabling condition to accomplish an essential job requirement. Signature also verifies that the item requested becomes the property of the receiving federal agency. Furthermore, equipment maintenance beyond initial warranty period and additional supplies after receipt of equipment is the responsibility of the federal agency. If you have any questions, please call CAP at 703-681-8813 (V) 703-681-0881 (TTY), or email CAP@tma.osd.mil. **Complete the form online at <http://www.tricare.osd.mil/cap/requests> or fax completed form to 703-681-9075 or send by US Mail to:**

DoD Computer/Electronic Accommodations Program Office

**TRICARE Management Activity
5111 Leesburg Pike, Five Skyline Place, Suite 810
Falls Church, VA 22041-3206**

CAP Request Form

Page 1 of 4

1. NAME OF PERSON OR OFFICE TO BE ACCOMMODATED (Please Print):	
Grade Level:	Occupational Series:
Are you a new federal employee?	
Have you used CAP services before? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please include your CUSTOMER ID # (if known):	
2. ADDRESS/CONTACT INFORMATION: (No P.O. Boxes - No acronyms)	
If your agency is within DoD (specify):	
DELIVERY ADDRESS (Work Address):	
Address1:	
Address2:	
City, State, Zip:	
Telephone/TTY#: (please indicate which)	
Fax #:	
Email:	

DISABILITY INFORMATION: Identify your disability

(Deaf/Hard of Hearing, Blind/Low Vision, Cognitive, Dexterity*: Additional information/medical documentation may be required to support the need of an accommodation per the Rehabilitation Act)

*Dexterity Disability (explain):

If you are a Workers' Compensation claimant, include your Workers' Compensation Claim # and copy of Department of Labor Claim Acceptance Letter.

If you Telework, include your agency agreement form.

Please fax supporting documents to 703-681-9075.

4. SUPERVISOR/POINT OF CONTACT INFORMATION (Complete all fields):

Name:

Signature:

Telephone/TTY #:

Fax #:

Email:

* * *

EQUIPMENT

* * *

5. ITEM REQUESTED: Include brand name/model and attach any vendor information/brochures you may have. If requesting Speech Recognition Software, complete and fax the Speech Recognition Information Form, located under "News/Documents" on the CAP Website. Please fill out a separate request for each item being requested.

6. JUSTIFICATION: Please explain how this item will assist you in performing your essential job functions:

7. COMPUTER SYSTEM: In order to establish compatibility, identify:

Operating System:

Win00: ☐WinNT: ☐Mac: ☐Win98: ☐Win95: ☐Other: ☐Does your computer have a USB Port? ☐ Yes ☐ No

How much RAM does your computer have?

8. EMPLOYEE SIGNATURE:

* * * FUNDED SERVICE * * *

Note: Complete this section only if you are a **DoD employee attending a training session lasting two or more days**. Mark your requested funded service:☐Interpreter* ☐CART* ☐Personal Assistant ☐Reader***Interpreter and CART Services are for DoD employees to attend information technology and computer-related training sessions.**Submit a **fully completed request** (sections A and B) at least **15 days** prior to the start of the training or travel.**A. TRAINING SESSION:**Name of the **DoD Agency** training sponsor?

Training/Course Title:

Course Location:

Course Dates:

Course Time:

Have you been officially registered for training?

B. INFORMATION ON SERVICE PROVIDER (INTERPRETERS, READERS, ETC.):

For interpreting service information refer to the CAP Interpreter Database, located under "Deaf Accommodation Services" on the Website, and for information on obtaining a personal assistant please refer to the CAP Personal Assistant Information Form, located under "News/Documents" on the website.

Agency/Service Provider Name, Point of Contact and Address:

Telephone/TTY #:

Fax #:

Cost/Quote (please attach):

Does service accept Credit Card Payment?

E-Mail:

Website:

Submitting this form signifies you agree to CAP terms and conditions.